CHAPTER INS 3800 – MEDICAL PROFESSIONAL LIABILITY INSURANCE MANDATORY REPORTING OF DETAILED CLAIM INFORMATION

GENERAL INSTRUCTIONS AND INFORMATION
FREQUENTLY ASKED QUESTIONS
Most Recent Update: December 1, 2006

Background: With the passage of Senate Bill 214 in June, 2005 (Chapter 197), the New Hampshire Legislature established that a mandatory Screening Panel process be followed for actions brought against health care providers because of alleged medical malpractice. Details of the law can be found under RSA 519-B. An important aspect of this legislation was the creation of a Medical Malpractice Panel and Insurance Oversight Committee, comprised of eight legislators. The purpose of the Committee is to review and analyze information provided by the administrative office of the courts and the insurance department related to medical injury liability claim activity in order to determine the effectiveness of mandatory screening panels. Part of their review is to analyze whether or not medical malpractice insurance premiums have been affected by the use of screening panels. A final report from this committee is to be submitted on or before December 1, 2010.

Ins 3800 was established by the NHID to formalize the process by which the insurance department can obtain detailed claim records to help in this analysis. We will be the conduit by which summary data is provided to the legislature and assist and guide the analytical process of comparing individual claim settlement activity with statewide premium trends. While there may be alternative possible uses for the data obtained under Ins 3800, it is important to remember that the primary purpose is to study the impact of the screening panel process in NH on the cost structure associated with medical malpractice insurance for NH healthcare providers (obtained from insurers or through self-insurance mechanisms).

General Instructions and Information: The department intends on updating this document on a regular basis to reflect updated procedures and questions received from reporting entities. It would be worthwhile to check the department's website regularly for updates.

- The department contact to whom questions and comments should be directed and to whom quarterly reports should be sent is:

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  New Hampshire Insurance Department
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  Questions can also be submitted via e-mail at: david.withers@ins.nh.gov.

- Ins 3800 specifies that "quarterly" reports are due at the department on or before January 10, April 10, July 10, and October 10. The rule also states that these reports should report on claims made against NH insureds during the preceding three-month period. Our expectation when drafting the rule was that standard calendar quarters (Jan-Mar; Apr-Jun; Jul-Sep; Oct-Dec) would be followed. However, because of comments received, the department recognizes that for some insurers the short time frame between the end of a standard calendar "quarter" and the tenth of the following month might be overly burdensome. Therefore an insurer has the option to report according to the following time schedule:

Report Due	Reported Months
January 10	Sep, Oct, Nov
April 10	Dec, Jan, Feb
July 10	Mar, Apr, May
October 10	Jun, Jul, Aug

  If an insurer chooses to report in this manner, the summary should clearly indicate the three-month period being included, and once started, this time frame should be followed for all subsequent submissions.

- Every quarterly report has two components. One component is comprised of completed "Medical Liability Insurance Claim Report" forms, one for each individual claim. The other component of the submission is a "Summary" report. The Summary Report is intended to be simply a listing of the individual claim reports included in that quarter's submission. The department will use it as a cross check that we have received and recorded every individual claim report the insurer is submitting. The list can be very basic – at a minimum show for each submitted individual claim report, the unique report ID number, an indication if the particular report is a new report or an update to an existing reported claim, and if applicable, a brief description of what has changed with the update.

- There are three data items which indicate that the NHID will supply codes for insurers to use. The following table shows how to obtain this information:

Item	Source
1c. NAIC Code (for self-insurers)	NHID Contact
3f. Specialty Code (for self-insurers)	NHID Contact
8c. Act or Omission Code	NHID Website

- Act or Omission Code. For the purposes of this report, the NHID will use the codes published by the National Practitioner Data Bank. The chart found on the department website is a copy of a NPDB document, "MMPR Act or Omission Codes".

- Ins 3801.03 (j) "Health care provider" provides a listing so that it is clear which categories of state licensed or approved entities fall under the umbrella of Ins 3801.04 Detailed Reporting Requirements. It has been noted that the Claim Report Item 3e – Profession Code of Insured does not provide a 1-to-1 alignment of the list of healthcare providers. The department's view is that Item 3e is intended to help group various providers in a smaller set of "profession" categories. With that perspective in mind, we ask that insurers choose the profession code that best fits the situation. For example a Physicians Assistant (because of the direct relationship with a Physician) might be coded in the '01' Physician and Surgeon category. However, if there is not a clear choice, or if the insurer is hesitant to arbitrarily assign a code, '99' is an acceptable option.

- The Instructions accompanying the Medical Professional Liability Claim Report Form indicate that an explanation should be provided for any items left blank. The department realizes that a common reason will be that the requested information simply is not available. If this is truly the reason, using the following words as the entry will be sufficient and will require that no further explanation be attached: "not available"; "unknown"; "N/A". The department will require an explanation to be included with the report only if there is another reason for the insurer to not supply the requested data.

- Insurers should only report on claims that they are directly involved with and only include information they have readily available, would normally be expected to have knowledge about, and is reflective of their business operations. In this regard, the following apply:

    - Insurers should only report on defendants represented by that insurer; identities of non-insurer related defendants may not be readily available;
    - If an insurer acts as a "reinsurer" or otherwise "backs-up" a self-insured health care provider, the insurer should not report on incidents that we would expect and require the self-insurer to report to the NHID. In other words we do not want to receive duplicative claim reports for the same incident – the "primary" insurer should be submitting the report;
    - The insurer might not separately establish reserves for loss expenses as a normal course of doing business. If this is the case, simply enter N/A in the appropriate field – a brief explanatory note on the report summary would be helpful;
    - Certain kinds of data may not be readily available to the insurer. For such items as economic, non-economic, and punitive damages, other indemnities paid, medical expenses, future medical expenses, wage loss and other expenses, the insurer should report that information which is known to the insurer.

- The department realizes that other states have reporting requirements related to medical malpractice insurance. Insurers may be using forms and means of reporting which are similar to the report form proscribed by Ins 3800. If an insurer would like to use an existing form of reporting which they feel only slightly modifies the NH form, we ask that they contact us first for approval. Because this form is part of a NH Administrative Rule, there is only a minimal amount of modifications we will be able to accept.

Questions and Answers:

Q. We are an insurance company licensed in New Hampshire but we do not write Professional Liability or Medical Malpractice insurance. Do we have to submit a summary report, indicating this to be the case?

A. No reporting is required.

Q. Is there a specific form to use for the Summary?

A. There is not a standard format to use. The information desired by the NHID is indicated above. The insurer can design a layout that works for them.

Q. How often does an insurer have to report or update information about a claim?

A. A claim should first be reported when a reserve is established by the insurer (item 9a should have a non-zero value). Once that occurs the only time a report needs to be submitted with respect to that particular claim is if there is a material change to the information already supplied to department, the indemnity or expense reserve is modified, a payment is made, or the claim is closed.

Q. If there is no activity in the past quarter on any claims, does an insurer have to notify the department of that?

A. There is no need for such notification.

Q. Ins 3800 became effective December 1, 2006. When is the first report due at the department and what period of time should it cover?

A. Because the Screening Panel system became operative in 2005, we desire to get as much information as we can on claims currently in the system. The first report is due January 10, and we intend to stay with that date, if at all possible. The rule specifies that claims, opened, modified or closed in the prior quarter, be to be reported. As mentioned above the prior quarter can be either Oct-Dec or Sep-Nov. We recognize that insurers may need some lead-time to make the necessary changes to their systems or operations. If an insurer will have difficulty in complying with the proscribed dates they should contact the department and we will work with the insurer on alternatives.

Q. In providing the requested information for Item 8a-Nature and Substance of Claim, how detailed is the department expecting the answer to be? We have concerns about the information required for other healthcare professionals involved in the claim.

A. We would like to receive, at a minimum, a description of the allegations. If there were other information as to any actions or circumstances causing the claim which might provide further insight, such information would be good to include. With respect to reporting on other healthcare professionals, there is no need to provide such information if it has been included on another claim report. We also understand that it may be difficult and/or inappropriate for an insurer to comment on healthcare professionals who are not their insureds.

Q. With respect to Item 11-Screening Panel Code, is it possible to use only one of the panel codes to indicate whether or not panel proceedings are in progress?

A. As mentioned earlier a major purpose of collecting this data is to help the NH Legislature determine the effectiveness of the Screening Panel Process. There are several stages of the process; the statute specifies time frames for certain stages; the average travel time for actions or suits in which screening panels are used is an important part of the review. The coding as set out in the instructions more directly delineates the stages. Therefore we believe that a code reflecting whether or not the panel has heard the case is important and we will require insurers to use both codes reflective of the appropriate stage.